MIGRAINE INFUSION ORDER FORM
P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Allergies: _____

Diagnosis: ☐ Migraine ☐ Other: _____ **ICD-10 Code:** _____

ACUTE MIGRAINE ORDERS

Pre-medications

- ☐ Reglan 10mg IV
- ☐ Pepcid 20mg IVP
- ☐ Solu-Medrol 125mg IVP
- ☐ Toradol 30mg IVP
- ☐ Zofran 4mg IVP – may repeat x 1
- ☐ Zofran 8mg IVP
- ☐ Benadryl 25mg IV
- ☐ Other: _____

☐ **Magnesium Sulfate** 1gm IV in250mL NS 1hr

DHE-45 ☐ 0.5mg **OR** ☐ 1mg IV in 100mL NS over 15 minutes
(Must pre-medicate for nausea) *max 2mg in 24 hours and/or 6mg/week*

Depacon ☐ 500mg **OR** ☐ 750mg IV in 250mL NS over 1 hour

Frequency ☐ One time dose ☐ Repeat regimen daily for _____ days ☐ Max treatment in 7-day period: _____

Standing PRN order (optional): ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 3 Months

Other Orders: _____

PREVENTION MIGRAINE ORDERS

Vyepti: ☐ 100mg IV every 3 months x 1-year ☐ 300mg IV every 3 months x 1 year

Robaxin: ☐ 1000mg IV every 2 weeks x 1-year ☐ 1500mg IV every 2 weeks x 1 year ☐ Other: _____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____